Preparing for Surgery for Post-Polio or Other Chronic Respiratory Disorder Patients

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CAREFUL PLANNING RESULTS IN PREVENTABLE COMPLICATIONS

1. PCP – Pulmonologist directly communicate with SURGEON(S) & ANESTHESIOLOGIST BEFORE ANY SURGERY & REVIEW IN DETAIL WHAT IS PLANNED & WHAT THE PATIENT NEEDS & WHY.
2. ALL comorbidities (other disorders such as Diabetes, kidney or other organ disorders) are attended to.
3. Make sure TEAM has list of ALL meds, including supplements as some may need to be stopped before surgery (Example: Fish-oil increases bleeding; Biotin interferes with accurate blood tests for heart damage) GIVE TEAM CELL PHONE NUMBER FOR PCP/PULMONOLOGIST
4. PRE-PROCEDURE REGIMEN FOR PATIENTS IN WRITING:
   a. Eat lightly soft foods-soups 2 days before surgery (less residue => less to poop)
   b. Take laxatives the day before surgery with Dulcolax &/or Miralax as post op anesthesia effects, bed rest & pain meds => CONSTIPATION & attempts to move bowels is painful with intrinsic inhibition = MORE STOPPAGE. Some may need enema(s) to clear.
   c. BRING ALL medications AND supplements on day of surgery so medication choices will be compatible, more effective with fewer potential adverse effects.
   d. Good oral hygiene (brush, floss, rinse. For some patients an oral antiseptic mouthwash, such as Chlorhexidine) Use as rinse, swirl, spit twice a day before & day of surgery, EVEN IF NOT EATING BEFORE SURGERY - AS ORAL BACTERIA MULTIPLY OVERNIGHT ("morning mouth"). Reduces risk of post-op pneumonia.
   e. Counsel on risks of STANDARD doses of pain meds (opiates, sedatives); use lower doses or alternatives. (Can always give more but cannot remove once in). Make sure TEAM is aware of YOUR past adverse experiences or allergies to medications, tape, any adhesive dressings.
   NO NEUROMUSCULAR BLOCKING DRUGS EVER USED.
5. If possible, have PCP or Pulmonologist PRESENT DAY OF SURGERY OR IN RECOVERY ROOM SO SHE/HE CAN CHECK PATIENT & WITH TEAM CARING FOR PATIENT. NURSES ARE USUALLY HAPPY TO HAVE THIS INPUT
6. If needed, ALLOW PCP/PULMONOLOGIST to take CHARGE over all non-surgical aspects of patient's postoperative care (takes the load off the surgical team). They may be relieved to add this MD to the post-op team.
7. If deemed appropriate, ICU bed post-op for closer monitoring.
8. For patients who already use non-invasive ventilators, extubate & restart HOME UNIT (patient familiar, acclimated & trusts system which allows sooner discharge).
   Note: Hospital Biomed Dept. has to clear Home units before use.
   - Can arrange to have unit in the hospital & checked on the day of surgery so by the time it is needed it is ready. The patient & the durable medical equipment company (DME) who provides the patient's vent brings the vent to the hospital, where the patient's MD arranges for Biomedical to clear the unit for post-op use.
9. If using Cough assist systems before surgery, restart as soon as possible per allowance by surgical site as to what unit will be preferred.
10. Respiratory Therapists are contacted prior to surgery to be on hand to facilitate any use of ventilation devices, oversee clearance, use of cough assists & nebulizer therapies.
11. Chest Physical therapy may be needed.
    - Use of Ambu bag (manual resuscitator which is applied to airway or mouth to increase lung expansion, prevents atelectasis & helps mucous clearance from airways with breath stacking & bigger air volumes) can help to reduce atelectasis (lung units collapsed) which reduces the supplementary oxygen levels & mobilizes more mucous. The larger air volume increases stretch of the chest & the recoil from decompressions mobilizes secretions better so suctioning is less needed & endotracheal tubes can be removed sooner. Less risk for pneumonia too.

    This all takes time & it is not well compensated by insurances. This regimen allows reduction of patient anxiety which improves the outcomes.

    Less anxiety => less stress => less stress hormone release => better outcomes.

    Having a trusted MD in proximity & taking over facilitates healing.

Many doctors fear to operate on patients who use ventilators. Pulmonologist can advocate strongly as these patients can be approached the same as other patients with only a little more attention to an individual's specific condition(s).